REQUEST FOR INDEPENDENT MEDICAL EXAMINATION
MAINE WORKERS' COMPENSATION BOARD
Office of Medical/Rehabilitation Services
27 State House Station
Augusta, ME 04333-0027
(207) 287-7062

EMPLOYER NAME:	EMPLOYEE LAST NAME:	FIRST NAME:		M.I.:
EMPLOYER MAILING ADDRESS & PHONE #:	ADDRESS - NUMBER AND STREET:			
INSURER NAME:	CITY:	STATE:	ZIP:	HOME PHONE:
INSURER MAILING ADDRESS:	DATE OF INJURY:	SSN:		
DIAGNOSIS/ICD 9 CODE:	PETITIONS PENDING:			

Attach a separate sheet of paper to add additional information.

Requester must define the disputed medical issues which require the opinion of an Independent Medical Examiner. Then, identify the specific questions related to the disputed medical issues which you submitted to the examiner.

Preferred specialty, if any, or independent medical examiner. The Board is not bound by such preference.

Identify All Interested Parties by Name, Address, Telephone Number and Client Name:

Requester Name, Address and Telephone Number:

WCB M-2 (11/01) DISTRIBUTION: PRACTITIONER (1) EMPLOYEE (2) EMPLOYER (3) INSURANCE COMPANY (4)